ASSURANT Employee Benefits

GROUP ENROLLMENT FORM

PLEASE PRINT CLEARLY IN BLUE OR BLACK INK

Group Name **Shelby County Tennessee**	Group Number	Effective Date / /

❑ **I apply for the following coverage for myself and dependents, as listed**.

Prepaid Plan

❑ **Plus**

Employment Status

❑ **Active** ❑ **Head Start (10-Month)** ❑ **Retiree**

Employee/Retiree First Name	MI	Last Name	❑ M ❑ F	Date of Birth / /	**Facility ID #**
Employee/Retiree Street Address	City	State / Zip		Employee/Retiree Social Security Number	
Home Phone ( )	Work Phone ( )	Division/Department/Class			Date of Hire / /

Dependents to be included for coverage:

First Name	MI	Last Name (if different)	Relationship	Sex	Date of Birth	**Facility ID#**
Spouse				❑ M ❑ F	/ /	
Child(ren)				❑ M ❑ F	/ /	
				❑ M ❑ F	/ /	
				❑ M ❑ F	/ /	
				❑ M ❑ F	/ /	
				❑ M ❑ F	/ /	

Check any boxes that apply and follow instructions.

❑ Are you covering more than three children? **Please continue listing on additional Enrollment Forms.**

❑ Is the address of any child different than the member's? **Show that child's name & address on the back of this form.**

❑ Are you requesting coverage for a dependent child other than a son or daughter? **Forward legal custody paper.**

❑ Are you requesting coverage for dependent child over age 26? **Furnish proof of incapacity within 31 days of the Effective Date.**

Please note it is the responsibility of the employee or retiree to remove a dependent when he/she is no longer eligible.

To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and they constitute the sole basis for, and are the inducement for, the issuance of any coverage. Please read the following and sign below.

The Prepaid Plan is provided and administered by Union Security Insurance Company.

I hereby apply for membership in this dental Plan for myself and for any eligible dependents listed above. I authorize the Group named above to make deductions, if any, required as my contribution. I agree, for myself and for any eligible dependents listed, to abide by the rules and regulations of the Plan and the terms and conditions of the Group Dental Service Agreement. I authorize any licensed dentist, physician, hospital or other health care provider to furnish Union Security Insurance Company and its affiliated dental companies with any required dental or medical information, as permitted by law about myself and any eligible dependents listed. I represent the information provided is true and correct to the best of my knowledge. I further understand that my coverage and benefits may be affected by failure to provide complete and accurate information. I will promptly advise the Plan and my Group of any changes in this information. The authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information. **IMPORTANT WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of benefits.**

Signature:_____ **Date:**_____

Office Use Only:

Employee (EIN) Number:_____ Entered by:_____

Comments: _____

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